SheridanEyeCare

Medical History Questionnaire

Today's Date: ____/____/____

Patient's Last Name: ____________ **First Name:** ____________ **MI:** ____

Address (mailing): ____________ City: ____________ State: ____ ZIP: ____

Phone: (H)____________ (W) ____________ (Cell) ____________ Birth Date: ____/____/____

E-mail: ____________ Occupation: ____________ Employer: ____________

SSN: ______ - ____ - ______ Insurance: ____________ Group and ID No.: ____________

Responsible Party's Last Name: ____________ **First Name:** ____________ **MI:** ____

Allergy
Medication Allergies: ____________ Environmental/Seasonal Allergies: ____________

Please indicate if you have any of the following conditions:

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke

Constitutional/General
- ☐ Dizziness
- ☐ Recent Sickness (flu, cold)
- ☐ Cancer: please explain:

Cranial/Facial
- ☐ Hearing Loss
- ☐ Sinus Problems

Endocrine
- ☐ Diabetes If yes, for how many years? _____
- ☐ Thyroid Disease
- ☐ Kidney Disease

Gastrointestinal
- ☐ Acid Reflux
- ☐ Crohn's Disease
- ☐ Liver Disease

Genitourinary
- ☐ Reiters
- ☐ Prostate Cancer
- ☐ Menopause

Hematologic/Lymphatic
- ☐ Clotting Disorder
- ☐ Anemia

Immunologic:
- ☐ Sjogren's
- ☐ Herpes Zoster (Shingles)
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Frequent Cold Sores

Integumentary/Skin:
- ☐ Rosacea
- ☐ Skin Cancer

Neurologic
- ☐ Headache/Migraine
- ☐ Multiple Sclerosis

Psychiatric
- ☐ Depression
- ☐ Attention Deficit Disorder
- ☐ Dementia

Respiratory:
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Please list other health conditions not mentioned above: ____________

Please list your primary care doctor: ____________

Height: ____________ Weight: ____________

Please see other side.

Please list medications you are taking: ______________________________

____

☐ I use cigarettes/tobacco regularly. ☐ I use alcohol regularly. ☐ I use other substances.

Family Medical History:
Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

☐ Diabetes Relation: ______________________________
☐ High Blood Pressure Relation: ______________________________
☐ Heart Disease Relation: ______________________________
☐ Cancer Relation: ______________________________
☐ Other Relation: ______________________________

Personal Eye History:

☐ I have had an eye operation. Which Eye? ________ Type: ______________ Date: ________
☐ I have had an eye injury. Which Eye? ________ Type: ______________ Date: ________
☐ I have glaucoma. ☐ I have cataracts. ☐ I have macular degeneration. ☐ I have dry eyes.
☐ I have other eye problems: ______________________________

Family Eye History:
Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

☐ Glaucoma Relation: ______________________________
☐ Macular Degeneration Relation: ______________________________

Lifestyle Questionnaire:

☐ I wear glasses. ☐ I wear contacts.
☐ I do not wear contacts, but am interested in them. ☐ I am interested in new eyeglass frames.
☐ I am interested in prescription sunglasses. ☐ I am interested in laser eye surgery.

Do you have trouble with:

☐ Glare while driving at night ☐ Light sensitivity ☐ Eyestrain while working on the computer
☐ Headaches resulting from eyestrain ☐ Double vision

To help us get to know you better and to better understand your visual needs, please indicate what hobbies/activities you are interested in:

____

____

Whom may we thank for referring you? ______________________________

Please sign below, indicating that (1) you have had the opportunity to read our Notice of Privacy Practices, (2) authorizing the release of medical or other information necessary to process your insurance claim, and (3) authorizing insurance benefits to be paid directly to Sheridan Eyecare Center.

Promise to Pay: I understand that I am responsible for all services provided to me by Sheridan Eyecare and its staff. If I fail to pay for the services when they are rendered or if I fail to pay for services that are not paid by my insurance company, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18 percent) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance for collection.

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Signature